SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Health Care Committee

BILL:	CS/CS/SB 2114
INTRODUCER:	Health Care Committee, Banking and Insurance Committee, and Senator Garcia
SUBJECT:	Florida's Motor Vehicle No-Fault Law
DATE:	April 6, 2006 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	**Fav/CS**
2.	Garner	Wilson	HE	**Fav/CS**
3.			JU	
4.				
5.				
6.				

I. Summary:

In 2003, the Legislature repealed Florida's Motor Vehicle No-Fault law.[1] Chapter law states that the repeal would take effect October 1, 2007, unless reenacted by the Legislature during the 2006 Regular Session. If reenacted, the law applies to policies issued or renewed on or after October 1, 2006.[2]

In November, 2005, the staff of the Senate Banking and Insurance Committee published, *Florida's Motor Vehicle No-Fault Law* (Interim Project Report 2006-102).[3] The Interim Report made the recommendation to reenact the no-fault law along with additional reforms to control costs, reduce litigation, combat fraud and provide resources to the Division of Insurance Fraud (DIF). This bill contains many of the recommendations made in the Interim Report to provide for the following:[4]

- Reenact Florida's No-Fault Law, but provide for future repeal on January 1, 2009;
- Combat insurance fraud by:
  - Providing that it is a second degree felony for a person to organize, plan or knowingly participate in a scheme to create documentation of a motor vehicle

[1] The affected sections are: ss. 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, F.S. Insurers are authorized to provide, in all policies issued or renewed after October 1, 2006, that such policies may terminate on or after October 1, 2007.

[2] Ch. 2003-411, L.O.F.

[3] See Report at: http://www.flsenate.gov/data/Publications/2006/Senate/reports/interim_reports/pdf/2006-102bilong.pdf (last visited on March 30, 2006)

[4] For the purposes of the single subject limitation, the other recommendations are contained in SB 2112 and SB 2116 (Senate Banking and Insurance Committee). Many of the insurance fraud recommendations are contained in SB 1124 (Sen. Posey) and SB 1596 (Sen. Alexander).

crash that did not occur ("paper" or "phantom" accident) and provides for a two year minimum mandatory term of imprisonment;
    - Expanding the applicability of the fraudulent motor vehicle insurance statute to provide that persons who present false or fraudulent proof of motor vehicle insurance commit a third degree felony;
    - Requiring specific information which must be in a crash report form and providing that the absence of information in a crash report, regarding the existence of passengers in the vehicle (involved in a crash), constitutes a "rebuttable presumption" that *no* such passengers were involved in the reported crash; and
    - Authorizing the Department of Highway Safety and Motor Vehicles (DHSMV) to revoke the driver's license of persons convicted of patient brokering, solicitation or participating in a staged motor vehicle accident;
- Provide for a total appropriation of $2,622,748 to fund 19 positions within the DIF and to provide a competitive pay adjustment of $10,000, plus benefits, for each of the existing 122 sworn law enforcement positions within DIF;
- Provide for a total appropriation of $750,000 to fund 6 additional insurance fraud prosecutors in 6 judicial circuits in Florida;
- Specify criteria for the Department of Health (DOH) to determine that certain tests are medically unnecessary under no-fault;
- Require insurers to provide policyholders and their assignees, upon written request, with a report itemizing all payments made with a copy of the insurance declarations page and insurance policy within 30 days after such request;
- Increase the number of days an insurer has to respond to a pre-suit demand letter from 15 to 21 days;
- Revise and clarify billing and coding requirements for providers;
- Reduce the number of days for a health care provider to submit charges to an insurer from 75 to 50 days, if the provider notifies the insurer within 21 days of first treatment;
- Require that providers of emergency services furnish a statement of charges within 75 days of the date treatment was rendered, with specified exceptions;
- Require PIP health care providers to give patients a written bill or similar document disclosing in plain language the treatment rendered and cost associated with such treatment at the time of service and to require the insured to sign the written bill or similar document and maintain a copy as part of the patient's medical records and provide exceptions for hospitals, emergency care and ambulance providers as well as providers who do not render services in the presence of the insured;
- Clarify that a parent or legal guardian of an insured minor must complete an application for PIP benefits;
- Require self-employed injured persons to produce reasonable proof to demonstrate loss of income and earning capacity to insurers;
- Clarify that if an insured elects to have disability benefits reserved for lost wages, the insured must notify the insurer in writing;
- Require that all amounts repayable to an insurer include the statutory interest penalty under s. 55.03, F.S.;
- Require that medical records of an injured person be available at the provider's principal place of business within 25 working days after a request for such records and if such

records are not made available within this time period and such records are later admitted into evidence or otherwise used to support a claim for benefits, the court shall not award attorney's fees to the provider;
- Restrict venue for a PIP lawsuit in cases where there has been as assignment of benefits to the jurisdiction where the injured party resides, where the accident occurred or where the disputed health care services were performed; and,
- Reorganize the statutory provisions of the personal injury protection (PIP) benefits section (s. 627.736, F.S.) for the purpose of clarifying its meaning and intent and for the purpose of better comprehension.

This bill substantially amends the following sections of the Florida Statutes: 316.068, 322.26, 627.736, 817.234, and 817.2361.

The bill creates five undesignated sections of law.

The bill repeals s. 19 of ch. 2003-411, Laws of Florida.

II. Present Situation:

Florida's Motor Vehicle No-Fault Insurance Law (Current Provisions, Mandatory and Optional Coverages, Tort Threshold, Financial Responsibility)

In 1971, Florida became the second state in the country to adopt a no-fault automobile insurance plan. The no-fault reform was offered as a viable replacement for the tort system as a means to quickly and efficiently compensate injured parties in auto accidents regardless of fault.

Under current law, motorists are required to purchase personal injury protection (PIP) and property damage (PD) liability coverages.[5] The no-fault coverage, referred to as PIP, provides $10,000 of coverage for the following: payment of 80 percent of reasonable medical expenses, 60 percent of loss of income, plus a $5,000 death benefit, for bodily injury sustained in a motor vehicle accident, without regard to fault. Personal injury protection covers the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the insured motor vehicle, and persons struck by the insured motor vehicle. This coverage also provides the policyholder with immunity from liability for economic damages (medical expenses) up to the $10,000 policy limits and for non-economic damages (pain and suffering) for most injuries.

Specifically, the immunity provision protects the insured from tort actions by others (and conversely, the insured may not bring suit to recover damages) for pain, suffering, mental anguish, and inconvenience arising out of the vehicle accident, except in the following cases:

- Significant and permanent loss of an important bodily function;
- Permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement;
- Significant and permanent scarring or disfigurement; or

[5] Ss. 627-730-627.7405, F.S.

- Death.

This is known as the "verbal threshold" which means that suits for pain and suffering may commence only if injuries meet these levels of seriousness.

Current law also requires vehicle owners to obtain $10,000 in property damage (PD) liability coverage which pays for the physical damage expenses caused by the insured to third parties in the accident. In addition, under Florida's Financial Responsibility law, motorists must provide proof of ability to pay monetary damages for bodily injury liability (BI) and PD liability after motor vehicle accidents or serious traffic violations. The minimum amounts of liability coverage are $10,000 in the event of injury to one person, $20,000 for injury to two or more persons, and $10,000 property damage, or $30,000 combined single limits. Many drivers purchase "optional" coverages in addition to mandatory insurance including bodily injury liability, (which may be required by the Financial Responsibility Law), uninsured motorist, collision, comprehensive, medical payments, towing, rental reimbursement and accidental death and dismemberment. Insurers may not require motorists to purchase any of these optional coverages.

The Legislature enacted significant no-fault reforms in 2001;[6] however, according to many stakeholders, these reforms have not gone far enough in resolving the problems within the no-fault system which include fraud, abuse, inappropriate medical treatment, inflated claims, inadequate compensation to victims, increased premiums, and the proliferation of law suits. As a result of these concerns, in 2003 the Legislature repealed the Motor Vehicle No-Fault law to take effect October 1, 2007, unless reenacted by the Legislature during the 2006 Regular Session and such reenactment becomes law to take effect for policies issued or renewed on or after October 1, 2006.[7]

Committee Staff Report and Recommendations

In November, 2005, the staff of the Senate Banking and Insurance Committee published, *Florida's Motor Vehicle No-Fault Law* (Interim Project Report 2006-102). The report found that Florida has a costly automobile insurance system with serious problems, though not at a "crisis" level. The market is competitive and coverage is readily available. Florida experienced significant premium increases, particularly for PIP coverage, from 1999 through 2003. But, this has been followed by rate decreases or very small increases in 2004 and 2005. PIP loss costs in Florida have also leveled off, but they have continued to outpace other no-fault states for at least the last five years. Loss costs for BI liability insurance in Florida are also well above the national average and higher than most no-fault states. High medical costs and utilization of medical services continue to drive PIP costs and the incidents of PIP fraud and abuse, primarily health care fraud, are at an all time high. Anti-fraud measures have helped to increase the number of arrests and prosecutions, but the resources of the DIF are limited.

The no-fault law meets the goal of compensating victims (and their medical providers) much more timely than under a traditional tort system. But, the efficiencies expected from no-fault due to decreased litigation and expense related to proving fault have not been fully realized due to the

[6] Chs. 2001-271 and 2001-163, L.O.F.
[7] Ch. 2003-411, L.O.F.

expenses associated with investigating and litigating the cost and utilization of medical services. However, reforms enacted in Florida in 2003 appear to have been effective in reducing such litigation. The report made the recommendation to reenact the no fault law along with other recommendations to control costs, reduce litigation, combat fraud, provide stronger regulation for health care clinics and provide resources to the Division of Insurance Fraud.

III. Effect of Proposed Changes:

Section 1. Amends s. 627.736, F.S., which applies to PIP benefits, reorganizing the section for the purpose of clarifying its meaning and intent, and for the purpose of better comprehension.

Subsection (1) requires an injured person who is self-employed, or an injured person who owns over a 25 percent interest in his or her employer, to produce to the insurer reasonable proof of income and loss of earning capacity, as a condition precedent to payment. The bill clarifies current law to provide that every employer shall, if a request is made by an insurer, furnish a sworn statement of earnings since the time of injury and "for a 13-week period" before the injury, of the person upon whose injury the claim is based.

The bill clarifies that if an insured elects to have disability benefits reserved for lost wages, the insured must notify the insurer in writing, which shall be binding on the insurer. Receipt of this notification will take priority over all claims subject to an assignment of benefits received after receipt of such notice. An exception is provided that if a properly perfected hospital lien is received by the insurer prior to the payment of the lost wage claim, the hospital lien will take priority over the insured's election to reserve benefits for lost wages. When the Agency for Health Care Administration (AHCA) provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the use of a motor vehicle, benefits under ss. 627.730-627.7405, F.S., shall be subject to the provisions of the Medicaid program. This provision is being moved from another subsection of the existing law.

Subsections (2), (3), and (4) renumber subsections in this section.

Subsection (5) reorganizes and modifies the requirement under current law that the DOH, in consultation with appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary as currently defined in s. 627.732, F.S., for use in either the diagnosis or treatment of persons injured under PIP. In determining whether a test is medically necessary for purposes of this subsection, the DOH may consider: the degree of positive diagnostic or treatment benefits in relation to costs; whether there is substantial demonstrated medical value for the injured person; the availability of alternative methods of treatment or diagnosis; the immediacy or remoteness of likely benefit for the injurer person; whether there is evidence of overuse of the test by providers for financial gain; whether there is acceptance of use of the tests; and whether there are reservations regarding the test as reported by the appropriate professional licensing boards. The DOH is directed to give greater weight to the advice of the licensing boards than to a degree of acceptance by individuals within the relevant provider community.

Subsection (6) reorganizes current law in this section pertaining to required payment of benefits by insurers.

Subsection (7) requires that medical benefits payable under s. 627.736, F.S., shall reimburse fully any payment made by the Medicaid program, up to the limits of coverage. The subsection states that a parent or legal guardian of an insured minor must, upon request of the insurer, complete an application for PIP benefits. The subsection also transfers current law to within this section regarding charges for treatment of injured persons and revises and clarifies the billing and coding requirements for PIP benefits to reflect current practices. Health information coding is the transformation of verbal descriptions of diseases, injuries, and procedures into numeric or alphanumeric designations. Currently, reimbursement of hospital and physician claims for Medicare patients depends entirely on the assignment of codes to describe diagnoses, services, and procedures provided.[8] The subsection requires all billings for services to comply with the Health Care Procedure Coding System (HCPCS). The (Physicians' Current Procedural Terminology (CPT)) coding system is deleted because HCPCS is a broader term that includes both the CPT coding system and the national coding system.[9] The current statutory reference to ICD-9 is removed and the correct, updated term is inserted: the International Classification of Diseases (ICD-9-CM). The "CM" refers to clinical modification and it is updated annually through a review process in order to make codes more precise due to new discoveries and medical advancements.

The subsection clarifies that claim forms submitted by providers (except ambulance providers, hospitals and physicians providing emergency care as defined in s. 395.002, F.S.) must include the "signature" and the "date" of the signature. The subsection inserts current law language pertaining to charges for specified medically necessary tests including magnetic resonance imaging services.

The subsection also clarifies that a statement of medical services may not include charges for services of a person that performed such services without possessing all valid "qualifications" and licenses "required to lawfully provide such services." However, the next provision states that a physician licensed under ch. 458 (allopathic physicians), ch. 459 (osteopathic physicians), ch. 460 (chiropractic physicians), or ch. 466 (dentists) F.S., may "delegate diagnostic or treatment tasks to an employee to be performed under the supervision" of the physician in accordance with the requirements and provisions of the applicable licensing section. Currently, there are employees who are not regulated or licensed under any licensing statute who provide diagnostic or treatment tasks under the supervision of a physician. For example, medical assistants provide such tasks in physician offices, but are not regulated or licensed under law or by any medical board. Their activities thus fall under the license of the physician and the physician's liability. There are no specifications in the bill detailing what diagnostic or treatment tasks an employee may perform and the term "supervision" is not defined.

Under the direct billing for PIP benefits provision, the subsection clarifies that the insurer may pay for charges directly to the "insured or the insured's assignee." Under this subsection, the

[8] See American Health Information Management Association site: http://www.ahima.org/ (last visited on April 1, 2006)
[9] The national coding system describes services and supplies not found in the CPT codes such as durable medical equipment, ambulance services, medical/surgical supplies, drugs, orthotics/prosthetics, dental procedures and vision services.

"timely billing for non-emergency services" requires the number of days for a health care provider to submit charges to an insurer to be reduced from 75 to 50 days, subject to the provider notifying the insurer within 21 days of first treatment. For "emergency services" provided under PIP, the legislation requires that such providers furnish a statement of charges within 75 days of the date treatment was rendered. Currently, there is no time limitation on submission of charges for emergency services. The subsection requires that if an insured fails to furnish the provider with the correct name and address of the insured's PIP insurer, the provider has 75 days following the date the provider obtains the correct information to furnish the insurer with a statement of the charges. However, the insurer is not required to pay for such charges unless the provider includes a statement with documentation of the incorrect billing to another PIP insurer.

Under the billing notice and disclosure provisions, a health care provider is required to give patients a written bill or similar document disclosing in plain language the treatment rendered and cost associated with such treatment on each date services are rendered. The insured must sign the written bill and the provider must maintain a copy of the bill or document as part of the patient's medical records. Exceptions are provided for hospitals, ambulance transport and treatment, emergency services and for providers who do not render services in the presence of the insured.

Insurers are mandated to provide policyholders and their assignees, upon written request, with a report itemizing all payments made with a copy of the insurance declarations page and a copy of the insurance policy within 30 days after the written request. The subsection inserts current law language providing that benefits are not due or payable on behalf of an insured if that person has committed PIP insurance fraud under specified circumstances.

Subsection (8) clarifies current law providing that PIP benefits paid will be overdue if not paid within 30 days after the insurer is furnished with "properly completed CMS 1500 form or its successor or UB 92 form or its successor, assignment of benefits, or, in the case of disability benefits, written documentation of the claim." The subsection also repeals provisions that are amended into other subsections of this section.

Subsection (9) specifies how the calculation of overdue payments is to be done.

Subsection (10) requires that all amounts repayable to an insurer must include the statutory interest penalty under s. 55.03, F.S.[10] The subsection also repeals provisions that are amended into other subsections of this section.

Subsection (11) renumbers current provisions related to claims that an insurer or insured is not required to pay. The subsection also repeals provisions that are amended into other subsections of this section.

Subsection (12) retains current law provisions providing for a demand letter which is a condition precedent to filing a lawsuit for PIP benefits. It prohibits the demand notice from being sent prior to the claim being deemed overdue. The subsection specifies what information must be included

[10] Under s. 55.03, F.S., the Chief Financial Officer establishes the rate of interest on December 1 of each year to take effect January 1st of the following year.

in such notice, how the notice must be delivered to the insurer, specifies conditions under which an action may not be brought against an insurer for delayed payments, but changes current law by increasing the number of days an insurer has to respond to a pre-suit demand letter from 15 to 21 days.

Subsection (13) renumbers current statutory provisions related to disclosure and acknowledgement form. The subsection also repeals provisions that are amended into other subsections of this section.

Subsection (14) retains current law as to requiring medical providers to provide certain information to an insurer upon request concerning claims, including a specific sworn statement that the treatment or service was reasonable and necessary. The subsection creates a new provision which requires medical records of an injured person to be available at the provider's principal place of business within 25 working days after a request for such records, if the records are maintained at an alternative location. If such records are not made available within this time period, and such records are later admitted into evidence or otherwise used to support a claim for benefits, the court shall not award attorney's fees to the provider under this provision or under s. 627.428, F.S. (attorney fees provision).

Subsection (15) renumbers current provisions of law related to mental and physical examinations of injured persons and what must be contained in reports on these conditions.

Subsection (16) renumbers current provisions of law related to how insurers must report cancellations or nonrenewals of PIP.

Subsection (17) renumbers the subsection related to preferred provider arrangements. The subsection also repeals provisions that are amended into other subsections of this section.

Subsection (18) retains and renumbers the current statutory language regarding civil actions for insurance fraud.

Subsection (19) retains and renumbers the current statutory language regarding minimum benefit coverage.

Subsection (20) retains the current law provision as to rewards for persons pertaining to improper billing by providers.

Subsection (21) restricts the venue as to PIP lawsuits in the case of an assignment of benefits to the jurisdiction where the injured party resides, where the accident occurred or where the disputed health care services were performed.

Section 2. Amends s. 316.068, F.S., relating to crash report forms, specifying information which must be in a crash report form including: time, date and location of crash; description of the vehicles involved; names and addresses of all witnesses, parties, passengers, and drivers; the name, badge number, and law enforcement agency of the officer investigating the crash; and the names of the insurance companies for the respective parties involved in the crash. The bill states that the absence of information in a crash report regarding the existence of passengers in the

vehicles involved in a crash constitutes a "rebuttable presumption" that no such passengers were involved in the reported crash.

Section 3. Amends s. 322.26, F.S., pertaining to the mandatory revocation of a driver's license by the DHSMV based upon conviction of specified offenses, adding convictions for solicitation under s. 817.234(8), F.S.; or participating in a staged motor vehicle accident under s. 817.234(9), F.S.; and for patient brokering under s. 817.505, F.S., to the list of such offenses.

Section 4. Amends s. 817.234, F.S., pertaining to the false and fraudulent insurance claims law, making it a second-degree felony (with a two-year minimum mandatory term of imprisonment) to plan or organize a "scheme to create documentation of a motor vehicle crash that did not occur" for purposes of a tort claim or for PIP benefits. This penalty currently applies to "staged accidents." According to representatives with DFS, criminalizing the activities of intentionally causing a "paper accident" would help deter motor vehicle insurance fraud.

The bill clarifies that any "service" provider (except a hospital) who waives deductibles or copayments as a general business practice commits insurance fraud. The provision also deletes the term "patient" and inserts the term "insured" to designate the person for whom, or entity for which, a service provider would agree to waive deductibles or copayments.

Section 5. Amends s. 817.2361, F.S., relating to false or fraudulent motor vehicle insurance, to delete the term "card" and to expand the applicability of the statute to provide that any person who presents false or fraudulent "proof of" motor vehicle insurance commits a third-degree felony. Current law makes it a third-degree felony to create, market, or present a false or fraudulent "insurance card."

Section 6. Provides that, for fiscal year 2006-07, $1,533,296 is appropriated on a recurring basis and an associated salary rate of 1,220,000 is authorized from the Insurance Regulatory Trust Fund to the DIF for the purpose of providing a competitive pay adjustment of $10,000, plus benefits, for each of the 122 existing sworn law enforcement officers in the division, in order to achieve relative parity with sworn law enforcement investigators who have similar responsibilities at other state law enforcement agencies. This appropriation is for the purposes provided in s. 626.989, F.S.

Section 7. Provides that, for fiscal year 2006-07, $510,276 in recurring funds and $111,455 in nonrecurring funds are appropriated from the Insurance Regulatory Trust Fund to DIF for the purpose of providing a new fraud unit within the division consisting of six sworn law enforcement officers, one non-sworn investigator, one crime analyst, and one clerical position. A total of nine FTEs and associated salary rate of 381,500 are authorized. This appropriation is for the purposes provided in s. 626.989, F.S.

Section 8. Provides that, for fiscal year 2006-07, $415,291 in recurring funds and $52,430 in nonrecurring funds are appropriated from the Insurance Regulatory Trust Fund to DIF and 10 FTEs and associated salary rate of 342,500 are authorized. This appropriation is for the purposes provided in s. 626.989, F.S.

Section 9. Provides that, for fiscal year 2006-07, $750,000 in recurring funds is appropriated from the Insurance Regulatory Trust Fund to the State Attorneys for the 4th (Duval), 6th (Pinellas), 9th (Orange), 13th (Hillsborough), 15th (Palm Beach) and 17th (Broward) Circuits to establish and fund an additional assistant state attorney position in each such circuit for the purpose of prosecuting cases of insurance fraud.

Section 10. Provides that effective January 1, 2009, specified sections[11] of the Motor Vehicle No-Fault Law are repealed, unless reviewed and reenacted by the Legislature prior to that date.

Section 11. Repeals s. 19 of ch. 2003-411, L.O.F. This deletes the law that repeals the Florida Motor Vehicle No-Fault Law, effective October 1, 2007.

Section 12. The bill takes effect October 1, 2006.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Art. VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Art. III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Insureds should benefit under the provisions of this legislation in that they will be given written bills disclosing in plain language the treatment they have received and the costs incurred for such treatment. Insureds are required to sign the written bill after receiving such services and copies of such disclosures must be maintained with the insured's records. Insureds will also benefit by the provision requiring insurance companies to provide the insured, and his or her assigns, documentation detailing payments made, the applicable insurance declarations page, and a copy of the insurance policy within 30 days

[11] These sections include: ss. 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, F.S.

of such request. Further, insureds should benefit by having the venue for any personal injury protection claim clarified by law to be in the jurisdiction where the insured resides, where the accident occurs, or where the disputed medical services are performed, if there is an assignment of benefits by the insured to the provider.

Providers will be required to sign and date specified claim forms submitted to insurers, provide bills or other documents to patients in "plain language" detailing the services provided and relevant costs, and provide medical records within a specified time frame.

Persons would be subject to specified penalties, including criminal prosecution, for various fraudulent insurance acts specified by the bill.

C. Government Sector Impact:

The bill appropriates $1,533,296 on a recurring basis and an associated salary rate of 1,220,000 is authorized from the Insurance Regulatory Trust Fund to the DIF for the purpose of providing a competitive pay adjustment of $10,000, plus benefits, for each of the 122 existing sworn law enforcement officers in the division, in order to achieve relative parity with sworn law enforcement investigators who have similar responsibilities at other state law enforcement agencies.

The bill appropriates $510,276 in recurring funds and $111,455 in nonrecurring funds from the Insurance Regulatory Trust Fund to DIF for the purpose of providing a new fraud unit within the division consisting of six sworn law enforcement officers, one non-sworn investigator, one crime analyst, and one clerical position. A total of nine FTEs and associated salary rate of 381,500 are authorized.

The bill appropriates $415,291 in recurring funds and $52,430 in nonrecurring funds from the Insurance Regulatory Trust Fund to DIF and 10 FTEs and associated salary rate of 342,500 are authorized.

The sum of $750,000 is appropriated from the Trust Fund to provide for six prosecutors in the designated circuits. These amounts are prorated for the 2006-07 fiscal year to conform to the October 1 effective date of the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

There are two other bills related to the Banking and Insurance Committee interim project report, *Florida's Motor Vehicle No-Fault Law* (Interim Report 2006-102): SB 2116 (public records, motor vehicle crash reports) and SB 2112 (health care clinics).

VIII. Summary of Amendments:

None.